# COSMETIC DERMATOLOGY & LASER CENTER

**REASON FOR VISIT:** ____________________________________________________________________________

| | | | |
|---|---|---|---|
| **Preferred Pharmacy Name** | _______________ | **What is the best number to reach you?** | ________________ |
| **Pharmacy City** | _______________ | **Can we leave a message at that number?** | ________________ _ |
| **Pharmacy Street** | _______________ | **Email address (optional)** | ________________ |

*Referral Information:*

How did you hear about the Cosmetic Dermatology and Laser Center?

☐ Google ☐ Mlive ☐ Physician ☐ UMHS Dermatology Clinic ☐ Post Card ☐ Friend/Family

If you were sent to us by a physician, please give us as much information as possible below:

Referring Physician Information:

Name: ______________________________________________________

Specialty (dermatology, primary care, etc.): ________________________

Address: ____________________________________________________

**Please circle if you currently have any of the following, if you circle anything please write the name of the doctor taking care of that problem next to that problem:**

| | | |
|---|---|---|
| Fevers | Chills | Heat/Cold Intolerance |
| Sores in the Mouth | Nausea | Easy Bleeding |
| Varicose Veins | Joint Pain | Difficulty Breathing |
| Pain with Urination | Depression | Unexplained Weight Loss |
| Dry Eyes | Recurrent Infections | Headaches |

**Are you pregnant or trying to get pregnant?** ☐ **Yes** ☐ **No**

**Past Medical History:**

| | | | |
|---|---|---|---|
| Basal Cell Skin Cancer | ☐ Yes ☐ No | Seasonal Allergies | ☐ Yes ☐ No |
| Squamous Cell Skin Cancer | ☐ Yes ☐ No | Asthma | ☐ Yes ☐ No |
| Melanoma | ☐ Yes ☐ No | Other Cancer | ☐ Yes ☐ No |
| Skin cancer surgery (Mohs) | ☐ Yes ☐ No | Heart Disease | ☐ Yes ☐ No |
| Laser Surgery | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No |
| Keloids | ☐ Yes ☐ No | Seizures | ☐ Yes ☐ No |
| Accutane (isotretinoin) | ☐ Yes ☐ No | HIV/AIDS | ☐ Yes ☐ No |
| Cold sores | ☐ Yes ☐ No | Myasthenia Gravis | ☐ Yes ☐ No |
| Lupus | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No |

## Family History:

| | | | |
|---|---|---|---|
| Basal Cell Skin Cancer | ☐ Yes ☐ No | Seasonal Allergies | ☐ Yes ☐ No |
| Squamous Cell Skin Cancer | ☐ Yes ☐ No | Asthma | ☐ Yes ☐ No |
| Melanoma | ☐ Yes ☐ No | Atopic Dermatitis (Eczema) | ☐ Yes ☐ No |
| Other Cancer | ☐ Yes ☐ No | Psoriasis | ☐ Yes ☐ No |
| Bleeding Disorders | ☐ Yes ☐ No | | |

## Social History:

**How often do you wear sunscreen?** ☐ **Most days** ☐ **only when I'm in the sun** ☐ **rarely or Never**

**Do you drink any alcoholic drinks?** ☐ **Yes** ☐ **No**

If yes, how many per week ______________

**Smoking History:** ☐ **Daily smoker** ☐ **Current smoker, but not every day** ☐**Former smoker/Quit date_________**

☐ **Never smoked** ☐ **Exposed to second-hand smoke** ☐**Smokeless Tobacco/Quit date______**

**Smoking damages your skin. If you currently smoke, please pick up an information sheet from the reception area detailing resources available to help you quit.**

## Medications:

Please list any medications you are taking including vitamins and supplements):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Allergies to medications:

______________________________________________________________________________

______________________________________________________________________________

Latex allergy? ☐ Yes ☐ No ☐ Unsure

Sensitivity to local anesthesia ☐ Yes ☐ No ☐ Unsure

If yes, please circle all that apply: Lidocaine Epinephrine

Please list any major current or past medical problems not noted above:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________